Success Behavioral Health Services *"We always have your success in mind"*

AUTHORIZATION FOR RELEASING and/or REQUESTING INFORMATION

I, _____ _____ _____
Client's Full Legal Name *Social Security Number* *Date of Birth*

authorize: CYNTHIA P. PALMAZ, LPC, LMFT, LSATP to ☐ disclose to *and/or* to ☐ receive from:

_____
Name of Individual and/or Organization to Whom Disclosure is to be made

_____
Street Address City State Zip

The Following Information:

☐ Discharge Summary
☐ Intake Summary/Mental Status Assessment
☐ Lab Results
☐ Psychiatric Consults/Notes
☐ Medication(s) Prescribed
☐ Diagnoses
☐ Progress Notes
☐ Treatment Plans
☐ Psychological and/or Psychiatric Testing
☐ Medical History & Emergency Medical Information
☐ Substance Abuse Information
☐ Social History & Behavioral Observations
☐ Verbal/Written Information Regarding Progress in Treatment
☐ All Confidential School Information (Education Eval. Reports & IEP)
☐ Psychotherapy Notes ONLY
☐ Other (Specify):_____

The Purpose for the Disclosure of this Information:

☐ Follow-up Medical Care ☐ Treatment Planning/Coordination of Services ☐ Other: _____

As the person signing this consent, I understand that I am giving my permission to the above-named provider to disclose my confidential health care records. I also understand that I have the right to revoke this consent at any time, except to the extent that action has been taken in reliance on it, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. If this authorization is for Psychotherapy Notes, it may not be used as an authorization for any other type of protected health information.

If not previously revoked, this consent will terminate One (1) year from the date of signature or until no longer reasonable necessary to accomplish the purpose for which it is given. If there are NO changes to the above information, this consent may be extended from the original date by re-signing below.

Signature of Client	**Date Signed**	**Signature of Parent/Legal Guardian**	**Witness**
_____	_____	_____	_____

NOTICE TO THE RECIPIENT OF THIS INFORMATION-REDISCLOSURE PROHIBITION: This information has been disclosed to you from records whose confidentiality may be protected by Federal Law. Federal regulation (42 CFR Part 2) prohibits the receiving agency from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to investigate or to prosecute any alcohol or drug abuse patient.